NEW YORK STATE DEPARTMENT OF HEALTH
Office of Managed Care

Provider Contract Statement and Certification

Please read the "HMO and Provider Contract Guidelines" before completing this form. Complete a separate statement for each provider contract or material amendment for which the HMO is seeking approval. If additional space is needed, attach a continuation page and identify the question(s) by number. **If all applicable questions are not answered, if answers are determined to be incomplete or inaccurate, or required supporting documentation is not attached, the agreement will not be accepted for review.**

Submission includes:

Date:

Check one:

‘ Contract

‘ Material Amendment of contract #:

Original approval date:

Original effective date:

‘ New contract using previously approved language

Original contract #:

Original approval date:

Original effective date:

‘ Contract Template[1]

Anticipated effective date:

HMO Unique Contract ID # (required, must also be indicated on contract):

Check method of standard clauses inclusion:

‘ Standard Clauses Appendix

The main body of the contract must expressly incorporate the Appendix and state that in the event of inconsistencies the Appendix controls. Identify the relevant provision.

Contract Page: | Clause:

OR

‘ Contract annotated to show location of standard clauses within agreement.

‘ A provision in the contract that expressly provides to incorporate DOH required revisions or to terminate the contract if so directed by DOH. Identify the provision.

Contract Page: | Clause:

‘ HMO Contractor's (and guaranteeing parent's if applicable) most recent certified audited financial statement.

‘ Proof of Financial Security Deposit (i.e., annotated bank statement)

Section A: Contracting Parties

1. HMO Name:

Contact Person: | Phone:

2. Agreement between:

‘ HMO and IPA[2] ‘ HMO and Provider ‘ IPA and Provider

3. IPA Name:	**4. Provider Name:**
Address:	Address:
City/State/Zip:	City/State/Zip:
Phone:	Phone:
DOH Use Only ON DOS: Y N ON DLA: Pend Aprvd N DOH CON ID#:	Type of Provider: ‘ Hospital ‘ Medical Group ‘ Individual Practitioner ‘ Other (describe):

[1] Templates may only be approved to form and cannot contain risk arrangements requiring DOH review as per the Contract Guidelines.

[2] Intermediate entities are limited to an IPA, Laboratory or Pharmacy and all should be treated as an IPA for the purposes of this form. Contracts between a HMO and IPA must be submitted together with the related agreements between the IPA and its providers. A separate Contract Statement and Certification is required for each agreement.

Section B: General Information

5. Briefly describe the purpose of this contract/amendment:

6. Check all Lines of business covered by contract:

- ‘ Child Health Plus
- ‘ Commercial
- ‘ Family Health Plus
- ‘ HIV SNP
- ‘ Medicaid
- ‘ Medicare

7. Contracted Services:

‘ Contract is for single directly-provided service ‘ Contract is for multiple services

a. Check all categories of health care services covered under the contract, each service provided directly by the provider, covered under the contract but through subcontracts with participating providers, and check each service if payment will be made FFS or with a withhold/bonus no greater than 25%, with no other risk sharing arrangement.

Category of Service Covered	Provided Directly	Covered/Not Directly Provided But Through Participating Provider Network	Service Paid FFS or Withhold/Bonus up to 25%
‘ Primary Care Physician	‘	‘	‘
‘ Specialist Physician	‘	‘	‘
‘ Hospital Inpatient	‘	‘	‘
‘ Ambulatory Surgery/Other Outpatient	‘	‘	‘
‘ Chiropractic	‘	‘	‘
‘ Dental	‘	‘	‘
‘ DME	‘	‘	‘
‘ Laboratory	‘	‘	‘
‘ Mental Health/Substance Abuse	‘	‘	‘
‘ Orthopedics	‘	‘	‘
‘ Pharmacy	‘	‘	‘
‘ Physical Therapy	‘	‘	‘
‘ Skilled Nursing	‘	‘	‘
‘ Vision	‘	‘	‘
‘ Other (describe):	‘	‘	‘
‘ Out of Provider Network Referral Services			

If agreement is between IPA and Provider, skip questions 7(b) through 13, proceed to Certification.

b. Does this contract delegate any management services[3]?

‘ Yes, identify the relevant contract provision and provide a brief summary:

Contract Page: Clause:

Summary:

‘ No

[3] Management services include: managing the HMO’s overall functions; recommending employment/termination of key management staff; preparing budgets and other financial data; and, on behalf of the plan: managing assets and liabilities; developing marketing and public information programs; performing utilization reviews; and conducting quality assurance/improvement activities.

c. Does this contract contain an "exclusivity clause" or most "favored nation clause" as described by items #28 and #29 in the HMO and IPA Provider Contract Guidelines?

‘ Yes, identify the relevant contract provision(s):

Contract Page:	Clause:

‘ No

Section C: Financial Arrangements Between HMO and IPA or Provider

8. Indicate payment methodology and any risk sharing arrangements for health care services in this contract (check all that apply):

‘ Fee-for-service

‘ Withhold or bonus
- ‘ Up to 25% of IPA/Provider payments
- ‘ Greater than 25% of IPA/Provider payments

‘ Capitation
- ‘ Prepaid
- ‘ Not Prepaid[4]

‘ Risk Pools (describe):

‘ Other (describe):

9. If "Withhold/bonus greater than 25%", "Capitation", "Risk Pools" or "Other" is checked in question #8:

a. What is the expected number of enrollees covered under this contract at the end of the first contract year?

b. What is the expected number of enrollee months paid under this contract for the first contract year?

10. Applicability of State Insurance Department (SID) Regulation for Capitation Agreements:

a. Does this contract's compensation FALL UNDER the SID Regulation 164 definition of prepaid capitation?

‘ Yes þ Does this contract **REQUIRE APPROVAL** under Part 101 of Title 11 of NYCRR (Regulation 164)?

- ‘ Yes, provide date contract submitted to SID for approval:
  - ‘ SID approval letter has been received and is attached.
  - ‘ SID approval not yet received.
- ‘ No, exempt because expected 12-month payments are: ‘ Less than $250,000 ‘ Less than $1,000,000

‘ No, compensation does not fall under SID Regulation 164.

b. Identify contract provision describing payment timing.

Contract Page:	Clause:

If all financial arrangements fall under SID Regulation 164, are fee-for-service, or are fee-for-service with a withhold/bonus of no more than 25%, or if the contract is for a single directly provided service (except hospital inpatient), skip questions 11-13, proceed to the Certification.

11. DOH Financial Viability Requirements:

a. Net worth of the HMO's contractor (Hospital, IPA, Provider): $ As of:

*The most recent certified audited financial statements (or comparable means, such as accountant's compilation) for the HMO's contractor **must be included with this package**.*

b. Is a parent company providing a guarantee for services and payment?

‘ Yes, identify the guarantee contract provision, provide a brief summary and indicate net worth of parent:

Contract Page:	Clause:	Summary:

Net worth of guaranteeing parent: $ As of:

*The most recent certified audited financial statements for any guaranteeing parent **must be included with this package.***

‘ No

[4] Capitation that is not prepaid per Part 101 of Title 11 of the NYCRR (Regulation 164) is not subject to Regulation 164.

c. HMO Monitoring Requirement: The HMO must monitor, on an ongoing basis, their contractor's financial capacity to support the transfer of risk. Identify the contract provision that describes the monitoring activities and timeframes and provide a brief summary.

Contract Page:	Clause:

Summary:

12. Out of IPA/Provider Network Services:

Identify the amount of funds the HMO will retain to provide out of IPA/provider network services (services covered under the contract but performed by providers not included in the HMO contractor's participating network) and identify the contract provision that states the HMO will retain the funds, pay the out of IPA/provider network claims, and perform a reconciliation within 6 months. Provide a summary of the reconciliation process.

HMO Retained Funds: $	Contract Page:	Clause:

Summarize how this was determined:

13. DOH Financial Security Deposit Requirements (refer to risk levels 1-5 of the Contract Guidelines)**:**

Is a financial security deposit required based on the Contract Guidelines?

‘ Yes

a. Project the total amount of compensation under this agreement for the 12 months from effective date of contract: $

Summarize how this was determined:

b. The financial security deposit must be 12.5% of the 12-month compensation payments in Q.13(a) less any payments to out-of-network providers included in Q.12. <u>Proof of the deposit, i.e., bank statement, must be submitted with this package.</u>

Amount of security deposit:
[*.125 x (12 mo. Projection – Out of network payments) = Financial security deposit*]

.125 X ( ) - ( ) = $

c. The HMO must monitor the security deposit to ensure it is sufficient to cover 12.5% of the actual annual contract payments. Identify the contract provision addressing this requirement and provide a brief summary.

Contract Page:	Clause:

Summary:

‘ No, indicate why a financial security deposit is not required:

Certification

The undersigned hereby certifies that to the best of my informed knowledge and belief the statements made herein and the documents attached hereto are accurate, true and complete in all material respects. The undersigned further certifies that I am knowledgeable **[*(For Corporate Officer)* and have been fully informed by legal counsel]** as to the statutes, regulations and guidelines applicable to the provider contract or amendment herewith submitted and that such contract or amendment is in full compliance with those applicable statutes, regulations and guidelines to the best of my informed knowledge and belief.

I further hereby certify that any changes or amendments to the applicable previously submitted and approved contract identified in this Contract Statement and submitted herewith are highlighted in the attached black-lined copies; that such previously submitted and approved provider contract language is clearly and correctly identified in this filing, and that all changes to previously approved language are to the best of my informed knowledge and belief, **[having been fully informed by legal counsel,]** in full compliance with applicable statutes, regulations and guidelines.

I understand that the New York State Department of Health is relying upon this certification as part of its review and approval process, and that should it be determined that this certification is materially false or incomplete or incorrect or includes incorrect, false or misleading, information, appropriate enforcement action will be taken.

Signature of HMO Officer or Legal (General) Counsel	Date
Print name of HMO Officer or Legal Counsel	Officer's or Counsel's Address
	City/State/Zip Code
Title	E-mail Address
Direct Telephone Number	HMO Unique Contract ID # (required)
Notary	